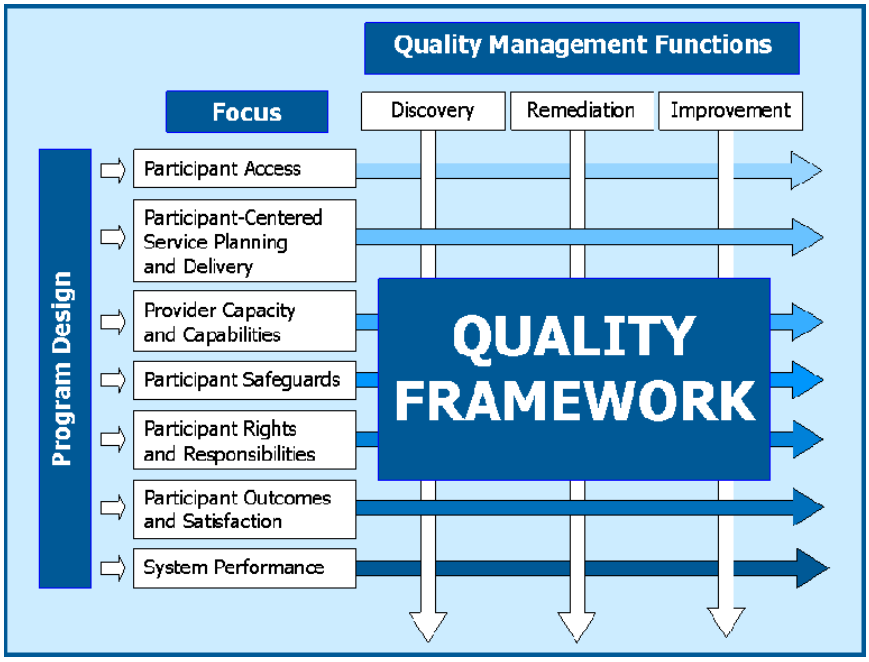
Appendix H: Quality Management Strategy



Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting the waiver assurances set forth in 42 CFR §441.301 and §441.302.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance is met.** For each waiver assurance, this description must include:

   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The roles and responsibilities of the parties involved in measuring performance and making improvements must be specified. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants individuals, advocates, and service providers;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.

2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements must be specified. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.

3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*

4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*

5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy**.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

Quality Management Strategy

The quality management strategy for the waiver is referred to as the Waiver for Older Adults Quality Assurance Plan. The six waiver assurances are addressed in this plan. The plan identifies the State and local agencies and their roles and responsibilities in providing oversight, interventions, ongoing monitoring and quality assurance activities related to each waiver assurance. The plan is designed to generate information and data that can be used to monitor and improve the manner in which the waiver operates.

Specific processes and monitoring strategies have been identified for each assurance and assigned to specific entities. These processes and monitoring strategies are intended to track compliance with waiver regulations and to help identify areas within the program that may need to be changed, or modified to improve the quality of services offered to participants.

The processes and monitoring strategies for each assurance are summarized below.

LEVEL OF CARE (LOC)

AAAs are responsible for initiating and coordinating the participant's LOC determination/redetermination process initially, annually, or as needed and involves several entities.

The Department will transition a new UCA for LOC determinations in early 2007. Transition planning will include written guidance, procedure manuals and training for the new UCA.

Process

- The AAA case manager is responsible for initiating and coordinating the level of care process.
- The AAA requests that AERS conducts a comprehensive and medical evaluation of the applicant which is forwarded to the UCA for a level of care determination.
- The UCA notifies the AAA of the LOC determination.
- If the applicant is denied medical eligibility, DEWS will send a denial of waiver eligibility letter which includes the information and process to request a fair hearing.

Monitoring

- MDoA monitors the timeliness of the initial LOC determinations and re-determinations by reviewing a report of timeliness produced by the waiver eligibility tracking system
- MDoA sends monthly LOC determinations and re-determinations reports to AAAs to assist them in tracking LOC determinations that are due in less than 30 days or have expired.
- DHMH performs a reliable and valid audit of the UCA for timeliness and appropriateness of LOC determinations at least semi-annually. If audit results indicate ongoing, systematic problems in LOC decision-making, DHMH will pursue a series of corrective actions including convening clinical staff to review cases in dispute and identify areas where training may be required, or conducting training for the UCA. Should training fail to improve performance, DHMH would increase the level of Departmental involvement in the decision-making process before issuing

notices to recipients. If these efforts failed to improve performance, the Department would pursue financial sanctions against the UCA and ultimately, as a last resort, terminate the UCA's contract.

- DHMH reviews the UCA *Long-Term Care Utilization Review and Summary Data Report* for WOA LOC determinations on a monthly basis.
- DHMH reviews all WOA cases that have been appealed for medical eligibility.

PLAN OF CARE (POC)

The Medicaid Waiver for Older Adults (WOA) Plan of Care (POC) development has many components involved to ensure that the services in the POC will address the participant's needs and choice.

Process

- The AAA a case manager is responsible for convening a multidisciplinary team which includes the AERS nurse or social worker, the client/representative, and any other involved providers (e.g., assisted living or other providers) to develop a waiver POC.
- The case manager develops a plan of care based on the AERS assessment and input from the multidisciplinary team. The plan of care must be cost effective and lists the type, amount, frequency, cost, duration, and provider of all waiver services. The plan of care is signed by all members of the multidisciplinary team.
- The case manager will revise the POC at least every 12 months, or more frequently if there is a significant change in the participant's condition or service needs.

Monitoring

- AAAs monitor the appropriateness of plan of care during quarterly on-site visits, including the implementation of the waiver POC by the ALM. The Case Manager is responsible for oversight of the Assisted Living Manager's implementation of the POCs. For participants living in ALFs, the ALM must complete a Manager's Assessment Tool, a part of which must be completed by a healthcare practitioner. A copy of the Manager's Assessment tool and ALF Level of Care rate form must be given to the waiver CM to complete the waiver POC. The initial and annual waiver POCs are not considered complete without provider signature(s). After completing the waiver POC, the CM must give all service providers a copy of the POC or furnish a Service Initiation form. In the Waiver regulations under the conditions of Participation for Assisted Living Facilities COMAR 10.09.54.05A (8) (b)-(d) it states that, "a provider shall:
  (8) Cooperate with other service provider and quality assurance monitors by:
  (b)Facilitating a case manager's on-site visits to the facility, which shall occur at least quarterly, to review the facility, regulatory compliance, service provision and participant status and needs,
  (c) Communicating with a participant's case manager concerning the participant's status needs and service provision,
  (d) Informing the case manager within one working day of any significant changes in the participant's and service needs.

  Assisted Living Regulations (COMAR 10.07.14.15) require each facility to have an Assisted Living Manager whose responsibilities include ensuring that there is appropriate coordination of all components of each resident's service plan and ensuring that that there is appropriate oversight and monitoring of the implementation of each resident's service plan. This oversight and monitoring would extend to the participant's waiver plan of care as well.

  While any member of the ALF staff, the ALM and/or the Delegating Nurse may communicate with the Case Manager, it is the ALM who is expected to be the main source of communication and it is the ALM with whom the CM communicates when conducting the quarterly review or the "as needed" visits.

- The IOC Team reviews each plan of care for a sample of waiver participants as part of the record

review at the AAA and an in-person participant survey.

- MDoA monitors the plan of care process by auditing a 5% sample of participant records annually to ensure proper procedures are followed and appropriate documentation is completed.

QUALIFIED PROVIDERS

MDoA and DHMH are responsible for assuring that qualified providers are enrolled to serve the needs of waiver participants.

Process

- MDoA verifies that provider applicants meet waiver requirements for provider enrollment, including licensure and additional certification requirements.
- MDoA maintains the provider information which includes the expiration dates of licenses.
- MDoA certifies that provider applications are complete.
- DHMH reviews provider applications and makes the final decision regarding provider enrollment
- DHMH enrolls providers in MMIS.
- OHCQ licenses assisted living facilities to provide level 1, 2 or 3 assisted living services.

Monitoring

- MDoA monitors personal care provider agencies by requiring them to submit monthly employee lists that attest that all employees are qualified to provide services under the waiver. If providers do not submit monthly lists, MDoA will withhold payment.
- MDoA maintains a provider database to monitor expiration dates for independent personal care provider credentials.
- MDoA conducts monthly random desk and on-site reviews of providers to ensure staff is properly credentialed.
- MDoA sends educational letters and conducts technical assistance meetings with providers to educate them on compliance with program requirements on a monthly basis or more frequently as needed.
- MDoA assesses provider network capacity on an ongoing basis.
- DHMH and MDoA conduct provider job fairs to recruit qualified providers on an as needed basis.
- DHMH and MDoA conduct semi-annual provider and AAA case manager trainings to address program policies, program changes, and billing information.
- DHMH and MDoA investigate administrative and quality of care complaints against providers on a daily basis. Complaints come in through the RE system.
- OHCQ monitors assisted living facilities by:
  - Monitoring ALF staffing:
    - all ALFs, regardless of size, are required to develop and update a staffing plan that takes into account the number of residents and the individual needs of each resident. The plan must identify the number of staff needed to provide the services required by regulation and include on–site staff sufficient in number and qualifications to meet the 24-hour scheduled and unscheduled needs of the residents. For example, if the participant's POC and AL service plan call for delegated nursing duties to be performed the ALF must employ staff who has the appropriate credentials and qualifications as required by Maryland Board of Nursing regulations.
    - The need, amount and frequency of nursing overview by the registered nurse is determined by the resident care needs regardless of the size of the ALF. The licensee must abide by all requirements of the Nurse Practice Act when arranging for the facility's delegating nurse/covergae.
    - OHCQ will determine if the ALM's managerial and administrative experience and education are sufficient to enable the ALM to perform the responsibilities required for the

residents the licensee intends to serve.

- MDoA monitors ALFs Level of Care
  - The case manager is responsible for assessing whether or not an ALF can meet the needs of a waiver participant. ALFs are prohibited from admitting a resident that has a higher level of care than the ALF is authorized to provide by OHCQ. A case manager would not place a participant assessed as requiring level 3 assisted living services in an ALF only licensed to provide levels 1 and 2. Additionally, Medicaid enrolls ALFs according to their licensed levels of care, therefore, MMIS would reject a claim for level 3 services submitted by an ALF only authorized to provide lower levels of care.
    If a participant's needs change from level 2 to level 3 and the facility is licensed accordingly, the participant may remain in place and receive enhanced services. If on the other hand, the participant's needs change and the facility is not licensed to provide that care, the ALF to request a "resident-specific level of care waiver" from OHCQ (this process is addressed in Appendix D-2:2). If OHCQ determines that a participant's needs cannot be addressed through a resident-specific level of care waiver, OHCQ will direct that the participant be relocated to his or her choice of an enrolled ALF that is capable of meeting the participant's needs. Another option would be for the participant and family to consider nursing home placement.

HEALTH AND WELFARE

A reportable event policy has been implemented to ensure the health and welfare of waiver participants. The reportable event policy is described in appendix G of this application and located on the DHMH website at www.dhmh.state.md.us/mma/waiverprograms.

Process

- AAAs are the direct contact for each waiver participant and are responsible for addressing problems that arise in the provision of services, assurance with choice and utilizing the reportable event policy and procedures to identify, follow up on and remediate problems.
- AAAs conduct quarterly and annual home visits to participants to monitor quality and appropriateness of the services and participant satisfaction.
- AAAs review and update each waiver participant's plan of care emergency and backup plan quarterly or as needed.
- AAAs initiate referrals to AERS or other appropriate agencies if there are significant concerns about a participant's health and safety.
- AAAs develop corrective action plans in response to IOC Team and MDoA reports regarding performance of case management duties.
- The IOC Team reviews a 5% sample of waiver participants by completing a record review at the AAA and an in-person participant survey.

Monitoring

- MDoA monitors the AAA for their compliance with program requirements by conducting annual on-site audits of the AAAs to verify timeliness of quarterly reviews and annual re-determinations, documentation of participant health status and service needs on a quarterly and annual basis, case manager notes for documentation of follow-up on quality and appropriateness of service issues and outcomes.
- MDoA reviews and resolves reportable events on a daily basis.
- MDoA follows up on AAA responses to IOC agency referral reports and CAP requests.
- MDoA tracks and trends reportable event data monthly and submits quarterly reports to DHMH.
- DHMH monitors implementation of the reportable event process by reviewing MDoA's quarterly RE reports.

- DHMH convenes and coordinates the Waiver Quality Council, analyzes and trends reportable event data to disseminate to MDoA and other stakeholders on a quarterly basis.
- The IOC Team develops a report for the AAA which may request corrective action plans that identify areas in need of improvement. .

ADMINISTRATIVE AUTHORITY

DHMH is the single state Medicaid agency responsible for implementation and oversight of the Waiver for Older Adults. MDoA is the operating state agency responsible for the day-to-day operations of the Waiver for Older Adults.

Process

- MDoA maintains a Medicaid waiver grant agreement with the AAAs outlining each entities role and responsibilities.
- DHMH and MDoA maintain a Memorandum of Agreement which outlines each administration's roles and responsibilities.
- DHMH and MDoA implement a Quality Management Plan that outlines in detail quality assurance activities and the entity responsible for that activity.
- DHMH and MDoA hold monthly interagency waiver coordination meetings to discuss current issues and policy.

Monitoring

- MDoA monitors AAA case management performance through annual on-site reviews.
- MDoA identifies the need for technical assistance and semi-annual training for case managers.
- MDoA reviews AAA quarterly administrative claims.
- DHMH requires MDoA to send quarterly reports on reportable events that includes trending and tracking of data and plans for remediation.
- DHMH uses the annual IOC Team reports to assess case management performance at the AAA.

FINANACIAL ACCOUNTABILITY

DHMH and MDoA are responsible for assuring the integrity of payments that have been made for waiver services.

Process

- AAAs develop and monitor plans of care to ensure individual cost neutrality.
- MDoA conducts a comprehensive analysis of DHMH claims reports for participant waiver expenditures.
- MDoA reviews provider claims for accuracy and appropriateness prior to submission to MMIS.
- DHMH and MDoA identify inappropriate payments and overpayments for recovery.
- DHMH places edits in MMIS to prevent inappropriate billing.
- DHMH and MDoA conduct financial audits.

Monitoring

- MDoA and the AAAs monitor provider claims for adherence to the participants' plans of care and to review service utilization quarterly and annually.
- MDoA conducts AAA audits to review cost neutrality annually or more frequently as needed.
- MDoA reviews Quarterly Cost Neutrality Report for participants with unusually high waiver expenditures that may potentially exceed the 12-month cost neutrality limit.
- DHMH uses the Medicaid Surveillance and Utilization Review Subsystem (SURS) Unit to identify problematic billing by providers.
- DHMH conducts audits of providers who have been identified as billing inappropriately.

REMEDIATION AND IMPROVEMENT

DHMH and MDoA have three primary forums for reviewing findings from discovery activities and moving forward to establish priorities and develop strategies for remediation and improvement. These are the:

- Waiver Quality Council
- WOA Waiver Advisory Committee
- Monthly interagency Waiver Coordination meetings

Waiver Quality Council (WQC)

The inter-agency WQC meets on quarterly to review findings from a variety of sources, such as RE data, licensing surveys, on-site reviews of providers, and AAA operational experiences. The primary source of findings is the quarterly RE data sent in by the operating State agencies. This data is aggregated and analyzed by OHS and the operating state agencies. Issues are tracked and trended for presentation to the WQC. It is then the function of the WQC to develop strategies for remediation and improvement. Since multiple issues will be identified quarterly, the WQC decides which issues should be the priority of the WQC to address. Development of the strategies is either addressed by the Council at large or assigned to smaller work groups.

WOA Advisory Committee

The quarterly Waiver Advisory Committee brings together providers, stakeholders, advocates and public agencies. The work of the WQC is shared with the Advisory Committee so that there will be an opportunity for DHMH and MDoA to benefit from a broader perspective due to the Committee composition. The Committee may also bring issues and concerns to the table that are different form those that come to the attention of the WQC, such as provider concerns. Some concerns will end up being referred to the WQC due to their complexity and need for study. For some issues, however, the Committee will be best positioned to propose meaningful strategies for program improvements.

Monthly Interagency Waiver Coordination Meetings

OHS and MDoA waiver administrative staff meet monthly to discuss policy, initiatives and problem areas of the waiver. Often there are administrative issues with the operation of the waiver that can be best addressed at this level. For example, at times it becomes clear that providers are not aware of certain practices they should be following to render services appropriately. The Waiver Coordination group may develop a strategy to provide written information to providers on this problem area. The group will assess at future meetings whether the strategy led to improvements in the problem or whether new strategies are needed. As appropriate, some issues will be raised to the level of the WQC by the Waiver Coordination group.

COMMUNICATION AND REPORTING

The methods used to compile quality data are described above with regard to the RE process. Additionally, reports are generated to produce data for critical decisions on quality management. Statistical and informational reports are developed by MDoA and DHMH to answer questions or provide explanations to members of the Waiver Advisory Committee with regard to quality management in the waiver. DHMH and MDoA communicate quality management information to providers and case managers through training, informational mailings and formal transmittals. The Waiver Tracking System is also a vehicle for communication to case managers. The primary method of communicating about quality management in the waiver to the general public is through the websites maintained by MDoA and DHMH or training opportunities.

EVALUATION AND REVISION

The WOA Quality Management Plan now provides a strong, basic framework for quality management. We have identified as a priority to implement routine provider trainings on an annual basis. A subcommittee of the WQC is planning to hold two provider training opportunities a year. Two months have been tentatively identified to hold the annual training. The agenda for the first training to occur this spring has also been set based on quality concerns of the WQC. The milestones to mark our progress will be the implementation of both training opportunities. Quality Management Plan will be revised as experience in operating the WOA leads us to and there will be a formal review annually.

The Quality Management Strategy used in the WOA is also used for two other Maryland home and community-based waivers. These are the Living At Home Waiver – 0353.01 and the Waiver for Children with Autism Spectrum Disorder – 0039.01.